Job Corps Health History Form

Your answers on this form will help Job Corps' health care providers get an accurate history of your medical concerns and conditions. These questions will help us get to know you better. This information is confidential. Please fill in all pages.

Diseases and Conditions

1. Have you ever had any of the following diseases or conditions?

Disease/condition	If yes, check this box	Disease/condition	If yes, check this box	Health and Wellness Center notes:
ADHD/ADD		High blood pressure		
Anemia/blood disorder		Joint pain/swelling		
Anxiety or panic attacks		Kidney/urine problem		
Asthma		Menstrual problem (F)		
Back problem/scoliosis		Mononucleosis		
Cancer		Seizures/epilepsy		
Chickenpox		Skin disorder		
Depression/suicide attempt		Sleep disorder/apnea		
Diabetes		Sports injury/fracture		
Headache/migraine		Stomach/bowel problem		
Head injury/concussion		Thyroid disorder		
Hearing loss		Tuberculosis		
Heart disease/murmur		Vision problems		
Hepatitis/liver disease		Weight problem		

Illnesses (circle yes or no)

2. Have you had a fever, rash, severe pain or cough in the past 2 weeks?* Yes No
3. Do you currently have any illnesses, problems, or concerns that you need to discuss <u>today</u>?* Yes No

Allergies

4. Do you have allergies to any of the following?

Allergen	List type (e.g., peanuts, dairy, specific medicine, cats)	Reaction (e.g., hives, trouble breathing)
Food		
Medicines or drugs		
Pollen, grass, hay fever, animals, or seasonal allergies		
Latex		

Student name: _____ Center: _____

DOB: _____ Gender: _____

ID #: _____ Race/ethnicity: _____

Medications

5. List all prescriptions and non-prescription medications, vitamins, supplements, home remedies, birth control, medications that help with your mood or behavior, herbs, inhalers, etc.

Medication	Dose (e.g., mg/pill)	How many times per day?	Reason

6. Have you stopped taking any medications in the past 3 months?* Yes No
7. Did you bring any medications with you?* Yes No

Surgical and Hospitalization History

8. Have you ever been in the hospital overnight? Yes No
9. Have you ever had surgery? Yes No
10. Have you decided not to have a recommended surgery? Yes No
11. Have you ever had a serious injury? Yes No

Family History

12. Has anyone in your family died for no apparent reason? Yes No
13. Has anyone in your family died of heart problems or of sudden death before age 50? Yes No
14. Does anyone in your family have :
    a. a heart problem, pacemaker or defibrillator? Yes No
    b. Marfan syndrome? Yes No
    c. high blood pressure, high cholesterol or diabetes? Yes No
    d. cancer? Yes No
    e. a history of mental health issues? Yes No
    f. sickle cell disease? Yes No

Oral Health

15. In the past 2 weeks, have you had any untreated dental pain or swelling in the mouth that has interfered with sleeping, eating, or ability to function?* Yes No
16. Do you have braces or retainers? Yes No
17. Do you need to talk with someone about something related to your mouth today?* Yes No

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Sports and Exercise

18. Has a doctor ever denied or restricted your participation in sports?	Yes	No
19. Have you ever passed out, or nearly passed out during or after exercise?	Yes	No
20. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	Yes	No
21. Does your heart ever race or skip beats (irregular beats) during exercise?	Yes	No
22. Has your doctor ever told you have any heart problems (such as high blood pressure, high cholesterol, a heart murmur, or heart infection)?	Yes	No
23. Has a doctor ever ordered a test for your heart (i.e., EKG or echocardiogram)?	Yes	No
24. Do you get lightheaded or feel more short of breath than expected during exercise?	Yes	No
25. Have you ever had a seizure?	Yes	No
26. Do you get more tired or short of breath more quickly than friends during exercise?	Yes	No

Eating and Weight

27. In the past year, have you tried to lose weight or control your weight by vomiting, taking diet pills or laxatives?	Yes	No
28. Have you ever been diagnosed with an eating disorder (e.g., bulimia, anorexia, binge eating disorder)?	Yes	No

Mental Health and Well Being

29. Have you had serious thoughts of suicide or have you tried to end your life recently?*	Yes	No
30. Have you tried to hurt yourself by cutting, burning, or any other way recently?*	Yes	No
31. Are you feeling like you might physically hurt someone recently?*	Yes	No
32. Are you currently feeling stressed out and need to talk with someone <u>today</u>?*	Yes	No

Alcohol, Drugs, and Tobacco

33. In the past 2 weeks, have you used alcohol or used drugs frequently or daily?*	Yes	No
34. Have you ever smoked cigarettes or used tobacco products?	Yes	No
35. Would you like to speak with someone about your alcohol or drug use?	Yes	No

Sexual History

36. Have you ever had sex?			Yes	No
37. Are you currently involved in a sexual relationship?			Yes	No
38. What best describes your past sexual partners?	Male	Female	Both	N/A
39. Have you ever been pregnant or gotten someone pregnant?			Yes	No
40. How often do you use condoms when you have sex?		Sometimes	Always	Never
41. Have you ever had a sexually transmitted infection or disease (e.g., Chlamydia, gonorrhea)?			Yes	No
42. Are you currently using any kind of birth control (e.g., birth control pills, Depo Provera, the ring, IUD, Implanon)?			Yes	No
43. Have you discussed birth control with your partner (if applicable)?			Yes	No
44. Would you like to receive birth control?			Yes	No

Female's Health History

45. Total number of pregnancies: _____ Number of births: _____
46. Date (month/day) of last menstrual period: _____
47. How would you describe your period? Heavy Medium Light

Student name: _____ Center: _____

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ID #: _____ Race/ethnicity: _____

48. How many days does your period last? _____

49. Do you get cramps or experience pain during your period? Yes No

Other

50. Please describe any other health problems that we should know about.

_____ _____

Student signature **Date**

For Health and Wellness Center use only.	
Nurse notes: All affirmative responses to questions denoted with an asterisk (*) must be addressed. Additional notable responses should be addressed.	
_____ Signature of nurse who reviewed above with student	_____ Date
Practitioner: Address any affirmative responses by number.	
_____ Practitioner signature	_____ Date

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DOB: _____ Gender: _____

ID #: _____ Race/ethnicity: _____